Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Donald M McPhaul MD

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-14-1605-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies per Rule 133.250"

Amount in Dispute: $728.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Donald Martin McPhaul has been appropriately reimbursed for services rendered to (injured employee) for 11/06/2013 date of service."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2013	99203, 95886, 95911, A4556	$728.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - U058 – Procedure code should not be billed without appropriate primary procedure
   - X133 – This charge was not reflected in the report as one of the procedures or services performed
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support additional reimbursement is due?
2. Was the level of service supported by documentation?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier reduced the disputed evaluation and management visit as, Z710 – "The charge for this procedure exceeds the fee schedule allowance." 28 Texas Administrative Code §134.203(c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (current year conversion factor)." The calculation of the maximum allowable reimbursement is calculated as;
    - Procedure code 99203, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.42. The practice expense (PE) RVU of 1.62 multiplied by the PE GPCI of 0.979 is 1.58598. The malpractice RVU of 0.14 multiplied by the malpractice GPCI of 0.826 is 0.11564. The sum of 3.12162 is multiplied by the Division conversion factor of $55.30 for a MAR of $172.63.
    - The total allowable reimbursement for the evaluation and management service in dispute is $172.63. This amount less the amount previously paid by the insurance carrier of $172.63 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

2. The remaining services in dispute were denied with the following reason codes; U058 – "Procedure code should not be billed without appropriate primary procedure", X133 – "his charge was not reflected in the report as one of the procedures or services performed." and B291 – "This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…"

   The American Medical Association (AMA) CPT code 95911 is defined as; "Nerve conduction studies 9-10 studies". Electromyography Report dated November 6, 2013 shows 8 studies.

   The CPT code 95886 is classified as an "add-on" code and is associated with primary procedure. This code must never be reported as a standalone code.

   Code A4556 is a bundled code and not payable separately. The Carrier's denials are supported.

3. Requirements of Rule §134.203 are not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.